Winter 2022

THE MEDICAL CORPS MAGAZINE

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MEDICAL CORPS
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MEDICAL CORPS MAGAZINE

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FROM THE CORPS CHIEF...

Shipmates, first let me thank you for your continued hard work in the midst of a Defense Health Agency transition, global pandemic, and all the other day-to-day work you are doing. What you do is important and Navy Medicine values you. Each specialty is unique and essential to complete our mission of increasing lethality through survivability. While many of the changes in force structure are challenging and perhaps frustrating, we are working to create the right size of the force for each specialty within our Corps.

One lever that can be confusing and is used to shape the Corps is the pay plan. Early in 2021, the National Defense Authorization Act for FY21 (NDAA21) was finalized. This increased the cap on Board Certification Pay (BCP) from $6K to $15K per year. Why hasn't your BCP increased? The reason is more complicated than you might realize.

The first "A" in "NDAA" stands for "authorization" and not "appropriation." Authorization gives the military permission to do something (like increase BCP to $15K), while appropriation actually gives them money to do so. In other words, the NDAA does not come with any funding, only authorization. Any authorization, like an increase in BCP, needs to be incorporate into the DOD budget. While Congress was approving NDAA21, the DOD was drafting the DOD pay plan for FY22 and the DOD budget for FY23. In other words, in a perfect world it would take 2 years after it was legislated for any NDAA related changes in pay to be considered, budgeted, and planned for.

Special pays in the DOD are managed by the Health Professions Incentives Working Group (HPIWG). The HPIWG is a triservice group that advises the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Within this working group, representatives from each service discuss special and incentive pays for health professionals and propose any changes, largely based on manning. Once the HPIWG has drafted the DOD pay plan, they send the draft to the ASD(HA) who approves the final DOD pay plan. The Navy then has 120 days to develop its own specific pay plan. As stated above, when NDAA21 was finalized, the HPIWG had already drafted the FY22 DOD pay plan and the DOD was working on the FY23 budget. In other words, the earliest the increase in BCP could be budgeted for and put into the DOD pay plan is FY23.

In addition to the fact that the Navy hadn't budgeted for the increased BCP, something called "up to" language also comes into play. For specialty specific incentive pay and retention bonuses (IP/RB), the Navy can pay "up

to" the full amount that is set in the DOD plan. This "up to" language does not apply to BCP, though, so if the DOD increases it from $6K to $15K per year then all the services must offer it to everyone who receives BCP. With about 2500 physicians in addition to those in other healthcare specialties receiving BCP, the total cost to the Navy would be about $27M per year.

What's the bottom line? It will take time for the DOD to consider the increase in BCP and, if they choose, to budget for it.

I hope that this explanation can help you understand the intricacies of the budget process at it relates to pay plans. Just know that when pays change it takes time for the budgetary processes to play out. While I can't promise what future pay plans will offer, I can promise that I will continue to advocate for you at every opportunity. Please don't hesitate to reach out to me or my staff if there is anything we can do to support you.

U.S. Navy Lt. Springli Payeur, a medical officer assigned to 3d Medical Battalion, 3d Marine Logistics Group, tends to a simulated critical care patient during Remote Island Disaster Exercise 2021, on Kadena Air Force Base, Okinawa, Japan, Nov. 2, 2021. RIDEX is a humanitarian assistance/disaster relief exercise between U.S. and Japan Forces that enhances the bilateral capabilities for casualty rescue operations and expeditionary medical assistance in the event of sudden disasters. (U.S. Marine Corps photo by Lance Cpl. Madison Santamaria)

PHOTO OF THE QUARTER:

NMRTC San Diego Performs Navy's First Corneal Neurotization Procedure

SAN DIEGO (Oct. 18, 2021) Lt. Cmdr. Katie Topping, an ophthalmologist assigned to Navy Medicine Readiness and Training Command (NMRTC) San Diego, performs the Navy's first corneal neurotization procedure in the hospital's main operating room complex Oct. 18. The procedure involves the transfer of a healthy nerve to reinnervate a damaged nerve within the eye. This potentially vision- and eye-saving procedure helps patients during the event of trauma, tumor or infection. NMRTC San Diego's mission is to prepare service members to deploy in support of operational forces, deliver high quality healthcare services and shape the future of military medicine through education, training and research. NMRTC San Diego employs more than 6,000 active duty military personnel, civilians, and contractors in Southern California to provide patients with world-class care anytime, anywhere. (U.S. Navy photo by Mass Communication Specialist 3rd Class Luke Cunningham)

SAN JUAN, Puerto Rico - (Nov. 27, 2021) – A Sailor assigned to the Freedom-variant littoral combat ship USS Sioux City (LCS 11) looks through the ship's binoculars during an outbound sea and anchor detail from San Juan, Puerto Rico, Nov. 27, 2021. Sioux City is deployed to the U.S. 4th Fleet area of operations to support Joint Interagency Task Force South's mission, which includes counter-illicit drug trafficking missions in the Caribbean and Eastern Pacific. (U.S. Navy photo by Mass Communication Specialist 3rd Class Juel Foster/Released)

Spotlight Article:

Detailing Update

Greetings from your Medical Corps Detailers based at Navy Personnel Command (PERS) in Millington, TN!

We would like to share with you who we are, what we do, and why this current detailing season is our most challenging in several years.

The Medical Corps Detailing shop currently consists of four detailers: CAPT Wayne Smith, CDR Rod Doss, CDR Tara O'Connell, and LCDR Derek Chamberlain. CAPT Smith is the senior detailer and the surgical specialty/executive medicine detailer. CDR Doss is the non-surgical detailer. CDR O'Connell is the family medicine, aerospace medicine, flight surgery, and undersea medicine detailer. LCDR Chamberlain is the OMO and GME detailer. The four of us work closely together. Detailers are your advocates in the assignments process. We are looking out for you and your career while balancing the needs of the Navy.

Here at PERS, we do not create or modify billets. We fill billets according to the billet files. The billet files are generated by the manpower requirement planners at the various Budget Submitting Offices (BSO) with BUMED (BSO-18) and the Marine Corps (BSO-27) being the two largest contributors. This is important to understand as any changes to the billet file must be executed by the appropriate BSO. Recently, you may have heard the term "fit to fill" used by your detailer or specialty leader. All billets have a rank associated with them. Part of our duty is to ensure the rank of the officer meets the requirements of the rank in the billet file. Most billets also have a specialty associated with them. We are also required to match the specialty and for many of our billets there is no substitution of specialty allowed. Billets that do not have an assigned specialty are advertised on our "Non-Specialty Specific" (NSS) billet list which is distributed via the Corps Chiefs office and the Specialty Leaders each fall.

Other members of the PERS team include Placement Officers and Order Writers. Placement Officers serve as advocates to the various commands. If a command has questions or concerns with manning, they should contact their supporting Placement Officer. If required, the Placement Officer will discuss the issue with the appropriate Detailer. This system allows each stakeholder to have an advocate while maintaining autonomy for the individual Detailers/Placement Officers. Conflicts are addressed at higher levels in the PERS chain of command. Orders Writers are enlisted Sailors at PERS that assist the Detailers in the final generation of orders that are released to officers. They are critical in ensuring the orders contain all the various text required to properly execute a Permanent Change of Station.

Many of you have heard of the transition of GMO billets to OMO (Operational Medical Officer) billets. While the transition is in the early stages, it's affecting our current detailing to both flight surgery and undersea medicine due to manning shortages in both communities. What does this mean for the Medical Corps at large? If you are a residency trained physician who has already completed a utilization tour in that specialty, you may be considered for a flight surgery or UMO billet for your next tour. If you're interested in volunteering to return to the flight or undersea medicine communities, please let the detailer of your residency trained specialty know! Fit to fill still plays a significant role in our flight and undersea billets.

As your advocates, detailers are looking out for your career. While physicians do not typically keep a strict sea/shore rotation like other communities, a diversity of billet assignments is key to career progression. The best leaders in Navy Medicine have generally held a variety of different roles in various geographic locations and complex environments, to include OCONUS. Staying in one geographical location for a prolonged period can potentially make you less competitive for promotion if not mitigated carefully.

Divestitures continue to be a hot topic. There are continued high-level discussions addressing the number and timing of possible divestitures. From the PERS perspective, we will attempt to fill all currently funded billets. This has resulted in several communities being functionally undermanned. However, as many of our medical specialties are undermanned, billets will be gapped. As the billets previously slated for divestiture are predominantly at CONUS MTFs, which is our lowest priority to fill, they may still go unfilled. We do not like gapping billets but we must fill our operational billets followed by our OCONUS billets. We also need to ensure the GME faculty at our CONUS MTFs is sufficient to meet the GME mission.

This summer two of our record keeping systems, OPINS and NSIPS, merged. This merge was not without challenges. Many officer records were affected. Examples of issues we have come across are AQDs added this summer

no longer showing on your OSR, incorrect subspecialty codes in your record, and board certification not showing on your record. The system is reconciling itself. But this year, more than ever, if you are eligible for promotion please ensure your record is correct in the months leading up to the selection board meeting. If it's not, reach out to your detailer. While we cannot correct everything in your record, we will be able to tell you who can. If corrections cannot be made in time for the selection board, we recommend submitting a Letter to the Board to address the issues.

Navy Personnel Command has created a comprehensive website to serve as a reference for career questions and references. We encourage you to check it out as it contains very useful information. MyNavyHR. In addition, you can email the service center to address any questions or concerns. askmncc@navy.mil

Due to the issues discussed, the key word for this detailing season is "patience." With so many competing priorities, the detailers must be strategic in how we negotiate orders. These are dynamic and difficult times. We do not want to modify orders we write which is why most CONUS MTF orders will not be written until after the New Year. We want to thank the entire Medical Corps for being so understanding of our predicament and for continuing to be patient with us. What you do as Navy physicians matters, especially over the last 18 months. The detailers are privileged to be your advocates and honored to serve alongside you.

ATLANTIC OCEAN (Sep. 18, 2021) Lt. Elizabeth Rettie, the family practice physician aboard the aircraft carrier USS George H.W. Bush (CVN 77), examines a patient during a drill. GHWB is operating in the Atlantic Ocean in support of naval operations to maintain maritime stability and security in order to ensure access, deter aggression and defend U.S., allied and partner interests. (U.S. Navy photo by Mass Communication Specialist 3rd Class Brandon Roberson)

Pacific Partnership 2021: Physicians Lead Adaptation to the COVID-19 Environment

By LT Danielle Wickman, MC, USN and LT Natalie Spritzer, NC, USN

Pacific Partnership originated in response to one of the world's most catastrophic natural disasters -- the December 26, 2004 "Boxing Day" earthquake in the Indian Ocean that resulted in a devastating tsunami. This mission has evolved over the years from an emphasis on providing direct patient care through the Medical Civic Action Program (MEDCAPs) model to an operation focused on enhancing partnerships through subject matter expert exchanges (SMEE), side-by-side patient care engagements, community health outreach teams, medical and nursing symposiums, and community health fairs.

Now in its 16th iteration, Pacific Partnership is the largest annual multinational humanitarian assistance and disaster relief preparedness mission conducted in the Indo-Pacific Region. The objectives of the Pacific Partnership mission are to work collectively with host and partner nations to enhance regional interoperability and disaster response capabilities, increase stability and security in the region, and foster new and enduring friendships across the Indo-Pacific Region.

KOROR, Palau (August 10, 2021) - U.S. Pacific Fleet and Center for Excellence in Disaster Management host a Humanitarian Assistance and Disaster Response workshop in the Republic of Palau, in support of Pacific Partnership 2021. Pacific Partnership, now in its 16th iteration, brings nations together to prepare during calm periods to effectively respond in times of crisis. Each year, the mission team works collectively with host and partner nations to enhance regional interoperability and disaster response capabilities, increase security and stability in the region, and foster new and enduring friendships in the Indo-Pacific. (U.S. Navy Photo by Mass Communication Specialist 3rd Class Andrew Langholf/Released)

The Coronavirus-19 (COVID-19) pandemic created a variety of challenges to planning and execution of the Pacific Partnership mission. For Pacific Partnership 2021 (PP21), initially several countries were going to participate, but by the later planning stages, several countries were unable. Before the mission began, teams were established that each included a Medical Lead Planner, Dental Lead Planner, Nursing Lead Planner, and Medical Admin Planner. The PP21 Senior Medical Officer was CAPT Nancy Miller, with CDR Philip Gaudreau acting as the Medical Team Lead for the Philippine mission.

This year's planning team utilized lessons learned from the Pacific Partnership 2020 team to execute virtual engagements in Papua New Guinea. This was the cardinal event of utilizing a virtual platform in Pacific Partnership. In addition, a team of 14 medical personnel conducted in-person engagements with the Armed Forces of the Philippines (AFP) in Manila. The commencement of the Philippines mission included transit from Guam to Manila via ship. The Military Sealift Command provided the USNS City of Bismarck (T-EPF-9), an Expeditionary Fast Transport (EPF) platform, to transport supplies and 9 medical team members. EPF ships provide rapid intra-theater transport and currently, two EPF platforms are under construction as Navy "ambulance ships" under an innovative model for maritime healthcare delivery and en route care at sea.

During our mission with the AFP in Manila, there were many lessons learned for conducting future global

health engagement (GHE) missions in the COVID-19 environment. Our team of physicians CDR Philip Gaudreau and LT Danielle Wickman led the way in this effort. At four sites we conducted multiple medical engagements, mostly in the SMEE format. The SMEE events centered on basic and advanced airway techniques, emergency department ultrasound, pain management, and head and neck trauma management. These highly relevant SMEEs were invaluable experiences that enhanced partnerships and collaboratively built capacity from innovative COVID-19 strategies shared by all participants. All of these SMEEs were additionally captured on Zoom, and AFP participants tuned in from their homes and offices as part of COVID-19 mitigation strategies. Traditionally, Pacific Partnership missions have focused on bolstering natural disaster response. This year that theme remained present, as our nursing colleagues conducted SMEEs on disaster nursing and mass casualty (MASCAL) response, including a MASCAL table-top exercise.

Among our PP21 engagements with the AFP, our medical presence was an invaluable focal point. This year's mission was a success in many respects, and it demonstrated remarkable agility in achieving mission objectives while navigating the constraints imposed by the COVID-19 environment. Through utilizing a combination of virtual and in-person engagements, the team reached a wide audience while reinforcing COVID-19 mitigation strategies. It is our vision that this model will serve as a prototype for future Pacific Partnership missions.

MEDICAL CORPS CHALLENGE COINS

For a limited time only, the 150th anniversary Navy Medical Corps Challenge Coins are available for purchase at **$13/coin**. Buy some for your friends for a discounted price, **$35 for 3 coins**, **$55 for 5 coins**, and **$100 for 10 coins**.

Don't forget about our classic coins as well, just $10/coin.

Contact Career Planner for further details:

rhett.a.barrett.mil@mail.mil

Concerned about Medical Malpractice? What you need to know!

by Douglas Pittner, MD, CAPT MC USN

Recently, there has been a lot of chatter about lawsuits against military physicians. A recent article was printed in Navy Times about how troops can file military medical malpractice claims. Naturally, all this discussion causes some valid concerns in the medical community and a lot of rumors and worry. Several questions have been posed to the military medical community over the past year regarding this new policy and I wanted to share some of the information I've obtained from my discussions with military health law experts. I am hopeful this will provide some reassurances to those who may be worried and some information to those who may be unsure how to proceed.

1. Has the new law increased the risk of malpractice lawsuits and liability for military physicians?

The National Defense Authorization Act (NDAA) of 2020 changed the law to allow military members to file a medical malpractice claim against the government. It has not, however, changed the liability protections of Navy medical doctors under either the Federal Tort Claims Act (FTCA) or Military Claims Act (MCA). Our military, civilian, and personal service contract providers have been and remain government employees and cannot be held individually liable for a medical malpractice payment so long as the alleged act(s) of negligence occurred while acting within the course and scope of employment. In other words, as long as we are practicing within the scope of our employment and clinical practice and are not committing intentional acts of negligence or harm to patients, we are covered under the FTCA and do not have any risk of personal financial liability.

2. Can active duty military members file a lawsuit against the government or physicians?

The NDAA of 2020 now permits active duty to file only administrative claims under the Military Claims Act (MCA). There is no judicial remedy for MCA claims (i.e. no ability to sue in court). Active duty members are still barred from filing claims or bringing lawsuits under the FTCA (i.e. they remain Feres barred).

3. Can a military physician be named as a defendant in a malpractice claim?

Per Federal Law, individual government employees cannot be named as defendants in FTCA medical malpractice actions. The defendant is always the United States Government and attorneys adjudicating those claims or defending these actions in Federal Court represent the Government. This means that the primary client is the government, not the individual provider. However, it should be noted that it is often in the best interest of the government to defend against medical malpractice claims/lawsuits by demonstrating the provider acted appropriately and met the standard of care.

4. If a physician is named in a malpractice claim, is he or she provided individual legal defense counsel?

The goal of government representation is limited to the interests of the government, so there is no individualized legal counsel provided to represent the sole interests of the provider; but there is no need for it because it is the government that absorbs the liability and defends against the claims.

5. What about settlements? Does a military physician have a voice in the decision on whether to settle a claim? Should a physician hire a personal attorney to represent his or her interests?

Claims and lawsuits can be settled for various reasons, such as nuisance settlements (when it's cheaper to settle than defend a valid case). Settlements can also be to the government's advantage when there is a lack of proper medical record documentation to verify the care that was provided at the time of medical service. Provider testimony alone may not be enough. Government attorneys do not have to consult or obtain provider approval to settle a medical malpractice claim. While providers could hire an attorney at their own expense to "represent their interest" in an ongoing malpractice claim or lawsuit, they are not

a named defendant to the action and they still have an obligation to assist government attorneys defending the case as any settlement or judgment is paid by the U.S. Treasury. Therefore, there is little need or value in hiring your own defense lawyer if you are involved in claim.

6. Can a claim be settled if the standard of care was met?

Standard of care can be met for an individual provider and there could still be a recommendation to settle based on systems errors or other considerations such as risk of an extremely high settlement or a particular point of law that presents significant concern for a bad legal precedent. The Navy legal system can still settle a claim if doing so is in the interest of the government, regardless of whether standard of care was met or not.

7. If a claim is settled, will the physician be reported to the National Practitioner Data Bank?

If a claim is settled, the government will pay that claim. If a provider is deemed to have failed to meet the standard of care leading to the settlement, then he or she can be reported to the National Provider Data Bank (NPDB). However, a report to the NPDB is NOT automatic. All paid claims and judgments are reviewed at HQ to determine whether any identified significantly involved providers failed to meet the standard of care. Each case undergoes several layers of review and the provider is offered an opportunity to submit a statement regarding his or her involvement in the case. The Report Authority (SG or DHA) makes the final decision on who gets reported to the NPDB. Generally speaking, if standard of care was determined to be met, then BUMED is historically less likely to report a provider to the NPDB. If a settlement is made and the provider is found to have met the standard of care, then the matter is generally referred out to an external reviewing agency for additional review. It is believed that DHA will follow that same process. Governing reference is DHA-PM 6025.13. A settlement related to a provider's care is not an automatic report to the NPDB.

8. If a settlement is made related to a physician's care, but BUMED/SG/DHA elect NOT to report that provider to the NPDB, what is the recommendation or obligation for that provider to answer questions regarding prior settlements on future applications and licensure renewals?

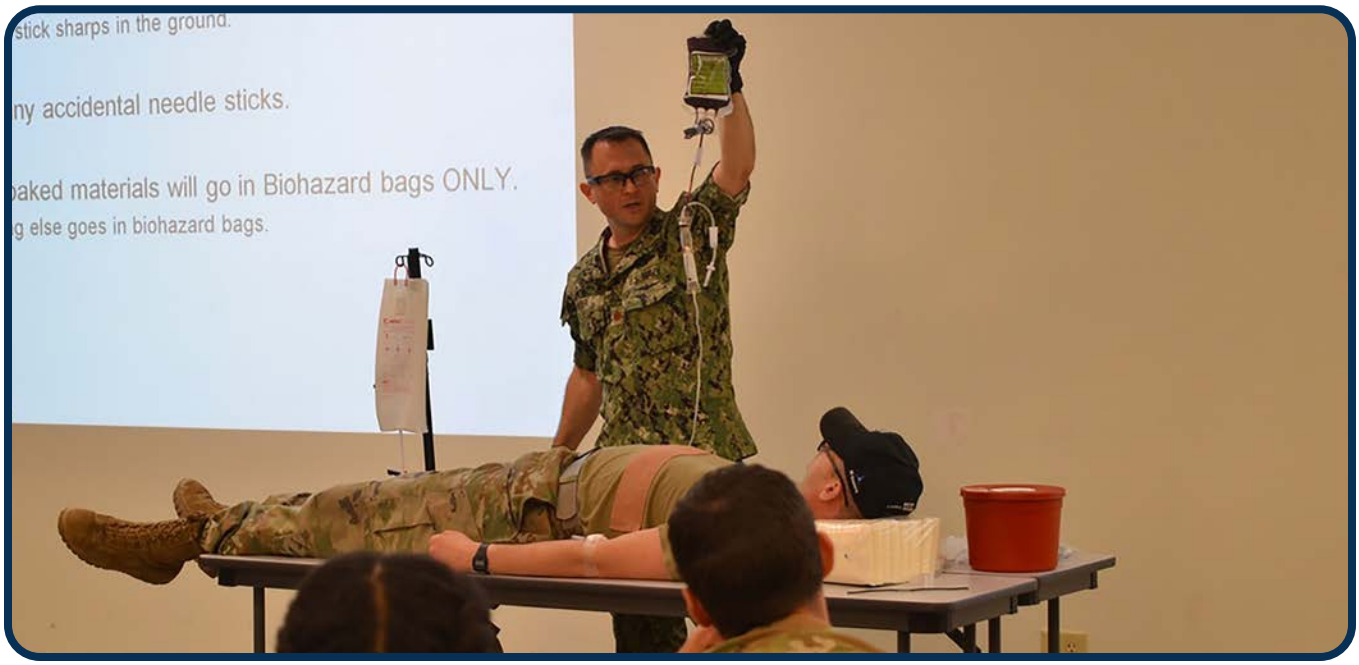
For example, a question on a licensure renewal form may ask, "Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement or arbitration?" How you answer the question totally depends on how it is worded. In general, the FTCA claims are filed against the Federal Government and not filed directly against the provider, so there may be latitude in answering that particular question. Most State licensure questions state "Have you ever been involved in a claim or lawsuit where the care you provided was at issue?" With that phrasing, the provider would likely need to answer yes, they were involved, and then explain the facts if the case was settled for some other reason or for a breach that did not involve their care. In general, it is better to self-report and then explain rather than to omit and have to explain after the fact. If an institution learned of a settlement and it was not reported on the application, the provider is then in the awkward situation of having to both explain the settlement and defend why it wasn't disclosed.

Bottom Line….

- No change in the underlying liability or protection for individual providers
- No need to alter your practice or pursue personal malpractice insurance or personal legal representation
- As always, stay within your lane. Practice in accordance with your training, experience and privileges. Know and understand the practice rules and regulations for any MOUs, ERSAs, or external agreements. Do not commit intentional acts of harm. Document care accurately.
- Be prepared for more legal review requests. As additional claims are submitted, it is expected that subject matter expert opinion will be frequently requested. Please understand that while this may seem like more work, reviews are shared among the community to ensure fairness. Having the ability to do these reviews gives us an opportunity to honestly assess and support one another.
- Enjoy the continued opportunity Navy Medicine offers for you to focus your priority on the needs of the patient without worry of personal financial liability.
- Trust that Navy Medicine leadership supports you. The system has a process that needs to play out, but at the top there are advocates in your corner.

2021 Joint Emergency Medicine Exercise: A Unique Training Opportunity for Graduating Emergency Medicine Residents

By LT Amanda Wojahn and LCDR Eric Koch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Fort Hood, Texas – Emergency medicine residents and medics sharpened their blood transfusion skills during the Joint Emergency Medicine Exercise June 8-11. Blood transfusion experts instructed students on whole blood transfusion before a student to student hands-on practice session. Lt. Cmdr. Russell Wier, medical officer, Navy Medical Center San Diego, and blood transfusion subject matter expert knows the value of medical personnel being able to perform whole blood transfusions on the battlefield.

On June 8-11, 2021, just weeks before completing residency, Navy Emergency Medicine (EM) PGY-4's took part in the Joint Emergency Medicine Exercise (JEMX). With many of these residents reporting to operational Marine commands immediately after graduation, this training opportunity was focused on people and performance; allowing residents to grow their operationally-focused knowledge, skills and abilities (KSA). The JEMX mission was to provide an initial understanding, familiarization, and appreciation of all echelons of medical care.

The 20 Navy EM residents (from NMRTC's San Diego and Portsmouth) gathered on Fort Hood with 14 graduating EM and Family Medicine residents from Carl R. Darnall Army Medical Center and 2 Air Force, University of Nevada EM residents. In total, 383 tri-service physician personnel participated in full mission profile training with an additional 1486 non-physician trainees.

During the first two days, lectures from the subject matter experts from all services were combined with labs and simulation training. Labs included familiarization with deployment ventilators and CO2 monitors, how to pack an aid bag, care for military working dogs, and autologous fresh whole blood transfusion. Lieutenant Commander Russ Weir, who developed the Valkyrie Emergency Whole Blood Training Program, provided instruction during the transfusion lab. This evolution provided the residents with hands-on experience collecting and transfusing fresh whole blood, as well as the knowledge to pass this training along to countless others throughout Navy Medicine. This will exponentially increase our team's ability to provide life-saving fresh whole blood transfusions when they are most needed.

The second half of JEMX provided practical training

LCDR Eric Koch prepares to start an IV in the back of a moving helicopter (Provided by Eric Koch)

in all echelons of care, from the point of injury (POI) to theatre evacuation. During the Theatre Movement Lane, combat casualties (cadavers and role players) received tactical combat casualty care (TCCC) from residents at the POI and were then transported to the Battalion Aid Station (BAS) via rotary wing MEDEVAC. Casualties were passed off to residents at the BAS who then led teams of medics, performing Damage Control Resuscitation and stabilized the patients. This provided real-world experience in leading a Shock Trauma Platoon, a role that many Navy EM residents will fill immediately after graduation. They were then transported via ground MEDEVAC to the Role 3 Field Hospital for Damage Control Surgery and post-operative stabilization. Military working dog patients were inserted at various echelons of care to challenge the residents even further. EM residents also had the opportunity to scrub in and be "first assist" in the Operating Room. Residents served at each echelon of care, providing combat care in this simulated forward-deployed setting.

After completion of Role 3 care, an Air Force Critical Care Air Transport Team (CCATT) familiarized residents on their specialized equipment, and then supervised residents performing patient packaging and simulated theatre evacuation on rotary wing MEDEVAC platforms.

Finally, residents had the chance to experience Prolonged Casualty Care (PCC). They were challenged with providing care to simulated combat casualties (perfused cadavers) in a resource-limited setting for 4 hours, an evolution designed to mimic the prolonged evacuation times that may be present in a near peer conflict. This was taught and supervised by tri-service physician proctors with real-world prolonged field care experience, many of whom with special forces background as well. This component of the training was critical, as EM physicians rarely practice many of these skills during residency training. Skills practiced during this session included whole blood transfusion, nursing care, documentation, sedation, analgesia, improved nutrition, hypothermia prevention, splinting, and wound and burn management. Additionally, residents performed advanced procedures to include REBOA placement, and fasciotomy and escharotomy with real-time telemedicine surgical consultation.

Ultimately, JEMX offered these graduating residents an invaluable and one-of-a-kind training opportunity to further enhance and practice the skills learned throughout the previous four years of residency. As a direct result of this exercise, Navy Medicine is provided additional power with a medical force that is ready for the next mission.

Army and Navy EM residens at the Point of Injury prepare to load a simulated casualty onto the rotary wing MEDEVAC platform. (Provided by CPT Hugh Hiller)

Meet the New Career Planner and Acting Deputy Corps Chief!

Captain Rhett A. Barrett was born and raised in the farmlands of rural Illinois. He graduated from Shiloh High School in 1995 and earned his Bachelors of Science degree from the University of Illinois Urbana-Champaign in 1999. Soon after that, he was selected for a four-year scholarship in the Health Professions Scholarship Program and commissioned as an ensign in the United States Navy Reserves. He subsequently attended the Kansas City School of Medicine and Biosciences (KCUMB) where he earned a Doctorate of Osteopathic Medicine in 2004.

Upon graduation from KCUMB, Barrett was commissioned as an active duty lieutenant in 2004 and underwent internship and residency training in pediatrics at Naval Medical Center Portsmouth (NMCP) in Portsmouth, Virginia. He graduated residency in 2007 and remained onboard NMCP for one additional year following residency as a staff pediatrician and served as the Chief of the Pediatric Residents.

His first duty station was at Naval Hospital Camp Lejeune in Jacksonville, North Carolina. While there, he received his board certification in General Pediatrics, became a Fellow of the American Academy of Pediatrics, and received an appointment as Assistant Professor of Pediatrics from the Uniformed Services University of Health Sciences. He was promoted to the rank of lieutenant commander in 2008 and served as the department head for pediatrics, medical director for inpatient pediatric services, and provided periodic support as a general medical officer to marine recruits at Marine Corps Recruit Depot Parris Island in Beaufort, South Carolina. Before leaving Camp Lejeune, Barrett was instrumental in developing the Navy's first Level IIB neonatal unit which significantly expanded services offered for critically ill and preterm neonates.

Following Camp Lejeune, Barrett was recruited back to Naval Medical Center Portsmouth as teaching faculty in 2011. He served as the division head of ambulatory pediatrics and was responsible for reorganizing the primary care clinic into two patient-centered pediatric Medical Home Ports which both achieved the highest level of recognition by the National Committee for Quality Assurance in 2012. While at NMCP, he served as medical director of the newborn nursery, associate program director of the pediatric residency program, and deployed with Pacific Partnership aboard the USS Pearl Harbor (LSD-52) in 2013. He promoted to the rank of commander in 2014 and served as the program director for the Navy and Air Force integrated Pediatric Residency Program from 2014-2018. He then promoted to the rank of captain in 2019 and served as Director for Professional Education, Director for Force Development, and the Designated Institutional Official at Naval Medical Center Portsmouth from 2018-2021. Barrett currently serves as the Career Planner for the Medical Corps at the Navy Bureau of Medicine and Surgery.

Barrett has received numerous national, regional, and local awards for clinical, academic, and teaching excellence. He was the recipient of the Outstanding Young Pediatrician Award from the American Academy of Pediatrics in 2010. The Uniformed Services University recently promoted him to the rank of Clinical Associate Professor of Pediatrics and the medical staff at NMCP selected him as a Master Clinician among the senior providers at the command. His military decorations include three Navy and Marine Corps Commendation Medals and a Navy Achievement Medal.

THE LEATHERNECK PHYSICIANS:

Part IV: Dr. Boone's Memoir, the Greenside and the Great War

By André B. Sobocinski, Historian, BUMED

In 1955—after 41 years of federal service—Vice Adm. (ret) Joel T. Boone set forth on one last journey—an epic voyage into his own remarkable life. Each day Boone retreated into the time machine of personal memory and narrated his military stories into a tape recorder. Over the next decade he recorded hundreds of hours of audio memoir as candid as the writings of Ulysses S. Grant and as entertaining as the recollections of Frank Harris (albeit without the exaggeration!) Like a Navy medical Zelig, Dr. Boone did it all; and like a Samuel Pepys centuries before, Boone documented all of it.

It is to the service of historians and service personnel alike that Boone spent those twilight years revisiting his past. Before his tenure in the civil service, Boone spent 36 years as a Navy physician establishing one of the most colorful, varied, and distinguished careers of anyone in military medical history. Boone was a Marine physician in Haiti during the occupation period, and a battalion surgeon

LT (later VADM) Joel Boone (second from right) with members of the 6th Marine Regiment at Verdun, France. Boone used the "cane" seen in photo to help maneuver through the muddy conditions and shell holes. Boone would write: "As time went on all officers and many of the enlisted men carried canes. [These canes] were almost indispensable in getting through the trenches, many of which were long, deep in mud over rough duckboards. Canes were not only useful in the trenches but very much so in the open fields which were rough and many times had shell holes and much of the traversing of the fields was at complete darkness, [and in] tremendous rainstorms."

in France at the height of the Great War. Later he served as the primary physician to three U.S. presidents and organized what is known today as White House Medical Unit. In World War II he was one of three officers selected by Admiral William Halsey to liberate American Prisoners of War in Japan even before the surrender documents were signed, and he represented the Navy Medical Department during those ceremonies on the deck of the USS Missouri. Post-war, Boone served as the medical director of the coal mine survey in 1946 and was responsible for the improvements of health and sanitary conditions in U.S. coal mining towns across the country. And during the Korean War, while on active reserve duty, he championed the cause of casualty evacuation by helicopter and can be credited with refitting hospital ships with helo-decks.

Boone acknowledges that his experiences on the greenside in Haiti and later in France represented the most transformative period of his life. Boone entered World War I an unknown and untested medical officer feeling his way in the dark of military protocol and procedures; after the war Boone was celebrated as combat physician, a veteran of Verdun, Vierzy and Belleau Wood, and a recipient of the Medal of Honor and Distinguished Service Cross.

For the remainder of his life, Boone would be that "hero doctor of the Great War," a distinction he carried with great humility. He would never forget his humble beginnings in the coal mining town of St. Clair, Penn., his experiences as a budding physician making house calls in the slums of Philadelphia, or the family, friends and mentors that helped guide him along the way. His memoir serves not as a monument to grandstanding or narcissism, but is an introspective and sincere narrative of a gentleman born of a now distant age. In Boone's world, history's forgotten enlisted Sailors and Marines are put on equal footing with the many dignitaries he knew personally. When he speaks of his accomplishments he talks of the unsung individuals that made them possible. In retreating from the spotlight his character shines brightest.

Dr. Joel Boone wearing the Tiffany Cross Medal of Honor. He is one of two Navy physician to receive the medal in World War I. To date, he is one of only four Navy physician to have received the award.

Boone had been in the Navy for almost three years when the United States declared war on Germany in April 1917. Like many of his Navy medical brethren, Boone deployed to France with the United States Marine Corps under the auspices of American Expeditionary Forces (AEF). In World War I, greenside Navy Medical personnel served in the 5th and 6th Marine Regiments and the 6th Machine Gun Battalion, all components of the famous 4th Marine Brigade, the most highly decorated unit in the war. The 4th's 331 Navy medical officers and Hospital Corpsmen would earn a total of 684 decorations and combat awards in France. Boone was among this distinguished pantheon, and one of only seven Navy medical officers serving in the 4th Brigade's 6th Regiment. He was one of only two Navy physicians to receive the Medal of Honor in the war.

Medical personnel with the Marine Brigade witnessed firsthand the horrors of trench warfare—trench foot, rampant disease, vermin, the complete absence of the most rudimentary hygiene, and the terrifying results of gas warfare—mustard, phosgene, and chlorine. Whether in the trenches or in makeshift Marine field hospitals (usually set-up in abandoned farmhouses and wine cellars), Boone tended to the effects of the first modern war—shrapnel, blast injuries, high projectile wounds, and post-traumatic stress disorder's antecedent, "Shell Shock."

In his memoir, Boone describes it all—the battlefields, the boarding houses, and the boredom of war; the field hospitals, camaraderie, the close-calls, and journeys into the unknown. He describes preparation for war, the field medical training at the newly established Marine Corps Base Quantico. He recalls the larger than life people he served with and met—Gen. Pershing, Col. Catlin, and the less well known Lt. Cmdr. Lester Pratt, and Hospital Corpsmen John Litchfield and Fred Shaffner; the latter two individuals would make the ultimate sacrifice on France's battlefields.

Boone never published his memoirs and to this day they remain one of many hidden treasures at the Library of Congress in Washington, D.C., available only to those researchers equipped with curiosity and persistence. But within those transcribed pages are many lessons of a life well-lived.

ARE YOU AN ALUM OF USUHS?

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If you are interested in helping with this initiative, whether as a mentor/sponsor to current or interested medical students or just available to answer questions, please reach out to ENS Derrick Knox at derrick.knox@usuhs.edu.

Want to contribute?

If you have an interesting story or some advice for the Corps? Always wanted to try your hand at writing? Email CDR Jennifer Eng-Kulawy with your ideas and see your article in the next edition of the Medical Corps Magazine.

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HAPPY HOLIDAYS AND HAPPY NEW YEAR FROM THE MEDICAL CORPS CHIEF'S OFFICE!

Rota, Spain - 2021 NMRTC Rota 3rd Annual Medical Corps Holiday Foto, (from left to right), CDR Doxey, LCDR Kutcher, LCDR Mulligan, CDR Agraz, LCDR Smith, CDR Wong-Lopez, CDR McDermott, LT Emerling, LCDR Engle, CAPT Kearns, CDR Gaspary, CAPT Brito (CO), LCDR Van Nielen, Santa Claus, CDR Yuan, LCDR Pierluissi-Jovet, LCDR Spears, LCDR Deskin, LCDR Lipscomb, LCDR Shirk, CDR Paz, LCDR Hammon, LCDR Lynn, LCDR Hauck